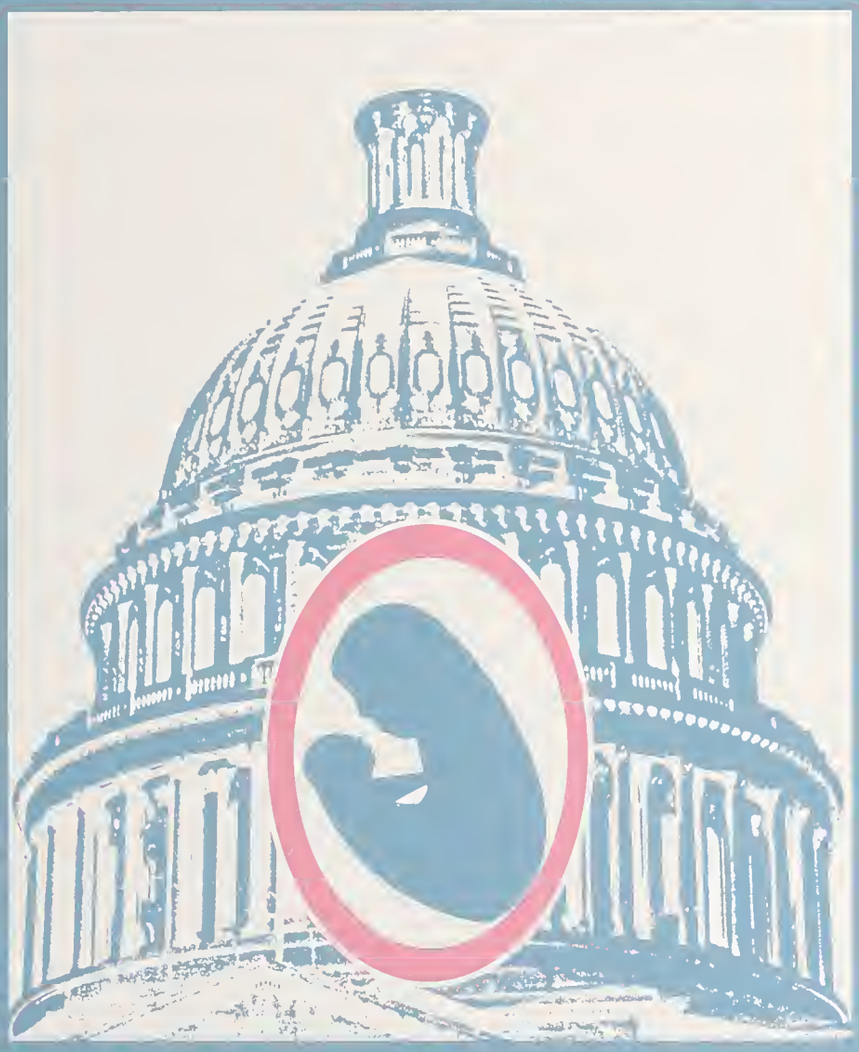
MATERNAL AND INFANT HEALTH:
MEDICAID STRATEGIES TO SAVE LIVES AND MONEY

A State's Opportunity



OCTOBER 1989

Medicaid Maternal and Infant Health

FOREWORDS

"...It will cost some more money to the States, but the costs of infant mortality are higher still.....The United States ranks 19th among world nations in infant mortality. We rank first in the world in the amount of money devoted to health care.....Yet our babies are dying at a disproportionately high rate."

— Louis W. Sullivan, M.D., Secretary of Health and Human Services, to the National Conference of State Legislatures, August 8, 1989

"The positive effects of early and comprehensive prenatal care are well known; increased use contributes directly to reduced incidence of infant mortality and babies born at low birthweight. Yet, the barriers poor pregnant women and children face in their pursuit of health care services can be monumental."

— National Governors' Association, Reaching Women Who Need Prenatal Care, 1988

"...providing good prenatal care is both the most effective strategy and the best bargain available to State governments to reduce the number of low birthweight babies."

— National Conference of State Legislatures, Saving Lives and Money: Preventing Low Birthweight, 1988

"Our fight against infant mortality has stalled because we have not reached the mothers and children at risk. We need to invest the kind of resources that provide preventive health care rather than waiting to provide costly 'rescue' treatment later."

— National Commission to Prevent Infant Mortality, Death Before Life, The Tragedy of Infant Mortality, 1988

A STATE'S OPPORTUNITY TO IMPROVE MATERNAL AND INFANT HEALTH THROUGH MEDICAID

I. WHAT IS ATTRACTIVE ABOUT LAUNCHING A MEDICAID EFFORT?

- The issue, as the National Conference of State Legislatures put it, is "Saving Lives and Saving Money." Early prenatal care has been proven cost effective:

  - The Institute of Medicine demonstrated that, because of the reduced need for neonatal intensive care and rehospitalizations, over $3 can be saved in the near term for every $1 spent for prenatal care of women at-risk.

  - We can spend the money now, or spend a lot more later. The National Commission to Prevent Infant Mortality noted that the costs of prenatal care, preventing low birthweight, can be as little as $400 per mother. The lifetime costs of caring for a low birthweight infant can reach $400,000.

  - In the case of infants born to low-income women, these costs are likely to be paid by Medicaid and/or public hospitals in the future.

- A substantial Medicaid effort, linked with other programs, can help to erase this country's poor performance among industrialized nations in terms of infant mortality. The effort can also help to reduce the disgracefully high infant mortality rates currently found among minorities.

- We are all concerned about the future labor force in our country. A healthy start in life is a critical factor in progressing toward becoming a contributing adult later.

II. WHAT CAN STATES DO TO LAUNCH AN EFFECTIVE EFFORT?

Take advantage of Federal Medicaid matching funds and technical assistance for enrolling eligible pregnant women in prenatal care, recruiting and retaining providers, and improving health care services. The following sections detail specific actions States can take to help reduce infant mortality and costly infant health problems in Medicaid eligible families.

A. ENROLL ELIGIBLE PREGNANT WOMEN

Outreach Programs

- Community health education campaigns to build a climate of public opinion and consensus on the need for prenatal care.
- Targeted outreach to those most difficult to reach and motivate: adolescents, drug abusers, alcohol abusers.
- Community residents as peer casefinders and helpers in navigating the eligibility and health care systems.
- Specific outreach programs for minority groups.

Streamlined Eligibility Processes

- Enable continuous eligibility throughout the pregnancy and post partum period, without regard to family income.
- Understand relief from fiscal sanctions for quality control errors associated with new Medicaid eligibility expansions.
- Ensure understanding that pregnant women are not required to establish paternity until after the child is born.
- Apply more liberal financial eligibility rules than those required for cash assistance programs for pregnant women.
- Locate eligibility workers where pregnant women seek care; e.g., hospital and health department clinics, and health centers.
- Establish presumptive eligibility, based on preliminary information on family income, to enable immediate access to ambulatory prenatal care while determining eligibility.
- Employ shortened application forms to collect only that information needed to determine eligibility for pregnant women.

B. IMPROVE RECRUITMENT AND RETENTION OF PROVIDERS

Address concerns about participation in Medicaid as revealed in National Governors' Association and American College of Obstetricians and Gynecologists surveys: (1) low reimbursement levels and slow payment; (2) paperwork and uncertainty about a woman's continuing eligibility, and (3) professional liability exposures and insurance rates.

- Raise fees, and add incentives to enhance physician participation in Medicaid prenatal care.
- Simplify claims payment systems, offer training and billing assistance to providers' staffs.
- Use "ombudsman" approach to provider relations, improve program perceptions, including liaison with medical societies.
- Increase use of alternative providers, as certified nurse midwives, nurse practitioners, clinics.
- Enact legislation to assist participating obstetricians in dealing with the high cost of liability insurance.

C. EXPLORE OPTIONS FOR SERVICE DELIVERY IMPROVEMENTS

- Employ targeted case management services to help individuals gain access to a comprehensive array of needed medical, social, educational and other services beyond Medicaid.
- Apply for freedom-of-choice waivers to permit establishing case management systems, specialty physician arrangements, and additional services for pregnant women and infants.
- Apply for home and community-based services waivers to provide enhanced services to individuals who otherwise would require services in a hospital or nursing facility.
- Offer family planning services incorporated in post partum care, preventive health services for youths and health maintenance for all women of child bearing age. Success in planning for pregnancy contributes significantly to reductions in infant mortality and health problems.
- Improve data systems and linkages of health, vital and Medicaid data to track effectiveness of programs aimed at assisting pregnant women and children.
- Continue to maintain and improve coordination among various health, income maintenance, and social service programs which assist pregnant women and children.

III. WHAT PROGRAMS FORM THE CORE OF A COMPREHENSIVE EFFORT?

No one profession, agency, program or level of government alone can reduce infant mortality and infant health problems. But each can make a difference.

MEDICAID is a Federal-State, means-tested entitlement program which provides medical assistance on behalf of pregnant women, children, families with dependent children, and aged, blind and disabled individuals whose income and resources are insufficient to meet the costs of necessary medical care. Medicaid programs are State designed and administered within broad Federal guidelines. Program and administrative costs are shared by the Federal Government.

- o States are required to provide Medicaid coverage of prenatal care and other pregnancy related services to women with family incomes up to 75 percent of the Federal poverty level (FPL) by July 1, 1989, and up to 100 percent of FPL by July 1, 1990.

- o Medicaid's **Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)** program for eligibles under age 21 can target specific services to at-risk infants, children and youth, including pre-pregnancy risk education for children and teenagers, and prenatal care for pregnant teens.

MATERNAL AND CHILD HEALTH (MCH) block grant represents the major Federal maternity care funding alternative to public and private insurance. Block grant funds are awarded to States for maternal and child health care to low income, underserved pregnant women, infants, and children. States may determine the services to be provided, with the exception of inpatient care, which is restricted to high-risk women and certain children.

SPECIAL SUPPLEMENTAL FOOD PROGRAM FOR WOMEN, INFANTS AND CHILDREN (WIC) provides health care referrals, nutrition education and counseling, and supplemental foods (e.g., infant formula, milk, eggs, and cereals) to low-income pregnant or nursing women, infants and children who are at "nutritional risk." States may set maximum eligibility limits between 100 and 185 percent of FPL, and WIC assistance may supplement assistance received by women eligible for food stamps. Nutritional risk, determined by a qualified health care professional, includes a history of poor pregnancy outcomes, iron deficiency anemia, and inadequate dietary patterns.

COMMUNITY/MIGRANT HEALTH CENTERS provide primary health care services in medically underserved areas, including: prenatal, maternity and pediatric care, family planning, diagnostic and emergency care, and transportation.

IV. HOW CAN STATES OBTAIN ASSISTANCE FROM HCFA?

HCFA Regional Offices have front-line responsibility for helping States, and have designated certain members of their staffs as Maternal and Infant Health Coordinators. These individuals are listed below:

Boston (I): Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont

Arthur Mazer
John F. Kennedy Federal Building
Room 1309
Boston, MA 02203
Telephone: 617-565-1247

New York (II): New Jersey, New York, Puerto Rico, Virgin Islands

Deborah Mayo
26 Federal Plaza
Room 3811
New York, NY 10278
Telephone: 212-264-2793

Philadelphia (III): Delaware, Maryland, Pennsylvania, Virginia, West Virginia, District of Columbia

Dan Soffin
3535 Market Street
P.O.Box 7760
Philadelphia, PA 19101
Telephone: 215-596-1300

Atlanta (IV): Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee

Wilma Cooper
101 Marietta Tower
Suite 701
Atlanta, GA 30323
Telephone: 404-331-2563

Chicago (V): Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin

Charlie Pearl Adams
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Dallas (VI): Arkansas, Louisiana, New Mexico, Oklahoma, Texas

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Dallas, TX. 75202
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Kansas City (VII): Iowa, Kansas, Missouri, Nebraska

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Kansas City, MO. 64106
Telephone: 816-426-3406

Denver (VIII): Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming

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Denver, CO. 80294
Telephone: 303-844-6216

San Francisco (IX): Arizona, California, Hawaii, Nevada, American Samoa, Guam, Northern Mariana Island

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Seattle (X): Alaska, Idaho, Oregon, Washington

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The Health Care Financing Administration (HCFA) is the Federal agency with responsibility for overseeing the Medicaid and Medicare programs

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